SEMMES MURPHEY
Leaders in Brain & Spine Care

Authorization to Obtain Protected Health Information

The purpose of this Authorization is to permit us to obtain all or some of your health information, as you specify, for the limited purposes you describe. We are otherwise required by federal law to maintain the privacy of your health information as described in our Notice of Privacy Practices. Your ability to receive treatment, payment, enrollment in a plan, or eligibility for a benefit normally does not depend on your signing this form. **You may refuse to sign this form.** However, we must have your signature in order to obtain your protected health information from the organization you identify below.

Redisclosure Statement: There is a potential that information disclosed pursuant to the authorization is subject to redisclosure by the recipient and no longer protected by HIPAA.

Revocation: You may revoke this Authorization in writing, at any time, except where we have already relied on it to obtain protected health information. Your written revocation will become effective once we receive and process it. If you wish to revoke this Authorization, please send your written request to: Privacy Officer, Semmes Murphey Clinic, P.C., 6325 Humphreys Boulevard, Memphis, Tennessee 38120.

Patient's full name (*please print*): ______________________________
Address: ______________________________
City: ____________________ State: __________ Zip: ________
Date of birth: ______/______/______ Patient SSN: ____________________

I authorize ______________________ to release my health information by mail/fax to:

Recipient's name: **SEMMES MURPHEY CLINIC**
Address: **6325 HUMPHREYS BOULEVARD**
City: **MEMPHIS** State: **TN** Zip: **38120**
Fax #: **(901) 259-2034** ATTN: Referrals

The following information from my medical record should be released:
□ Complete medical record □ Laboratory results □ Progress notes □ Other (*specify*) ____________
____

The information can be obtained at the signed request of the patient or patient's personal representative.
The purpose or need for the information is *(optional)*: ______________________________

Expiration: This Authorization expires on the date you specify below or six months from date signed, whichever is earlier. Once this Authorization expires, we will no longer be able to obtain your health information for the described purposes unless you sign a new Authorization form.

This Authorization expires (*check one*):
□ In six months □ On the following date other than six months: ______ / ______ / ______
□ When the following event occurs: ______________________________

____
Signature of patient or personal representative*

____
Printed name of patient or personal representative

____
Date

____
Relationship to patient (if personal representative)

*If Personal Representative, the patient is unable to sign because (check one): □ Minor □ Incompetent
□ Other (explain): ______________________________

For Office Use Only □ All complete □ Proof of I.D. □ Signed copy to patient
Processed by: ______________________________ MRN ____________________